1 CP Place PLLC
Telemedicine/Telehealth Participation Consent

Patient Name: ________________________________ Patient Date of Birth: ____________________

Thank you for choosing 1 CP Place PLLC. As your health care provider, we require that you read and sign this consent to participate in a telemedicine/telehealth consultation prior to any telemedicine/telehealth appointment.

- I understand that 1 CP Place PLLC offers telemedicine/telehealth consultation using a HIPAA compliant and secure video platform online. I further understand that my participation in a telemedicine/telehealth consultation is voluntary and that I am not required to participate in a telemedicine/telehealth consultation.
- I understand that the video conferencing technology used will **<u>not</u>** be the same as a direct patient/health care provider office visit, due to the fact that I will not be in the same room as my health care provider.
- I understand that although the video platform is a HIPAA compliant, secure encrypted format, there are potential risks using this technology, including interruptions, unauthorized access, and technical difficulties.
- I understand that my health care provider or I can discontinue the telemedicine/telehealth consultation at **<u>any time for any reason</u>**.
- I understand that if others are present other than my health care provider, they will maintain the confidentiality of any information obtained in accordance with all HIPAA guidelines. I further understand that I will be informed of their presence and will have the right to request the following:
    - omit specific details of any medical information to be discussed
    - ask that others present leave the telemedicine/telehealth exam room
- I understand that I am not obligated to participate in any telemedicine/telehealth consultation and that there are other alternatives to telemedicine/telehealth consultations.
- I understand that my insurance will be billed for a telemedicine/telehealth office visit for the time spent in the telemedicine/telehealth consultation with my health care provider. I further understand that I will be fully responsible for any copay, coinsurance, or deductible amount as determined by my insurance, and for any services not covered by my insurance, in compliance with local, state, and federal law.

By signing below, I certify that I have read and agree to the provisions stated above, and that I fully understand the risks and benefits of telemedicine/telehealth consultations.

________________________________ ____________________
Patient / Parent / Guardian Signature Date

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Printed Name

Version 2020-03-30